

² 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant sustained more than 3.75 percent binaural hearing loss for which he received a schedule award.

FACTUAL HISTORY

On October 27, 2015 appellant, then a 57-year-old insulator leader, filed an occupational disease claim (Form CA-2) alleging that he developed binaural hearing loss as a result of high levels of employment-related noise exposure. He was employed as an insulator leader from 1981 to 2014 where he was exposed to noise six to eight hours per day from various pneumatic tools, chipping, grinding, needle guns, deck crawlers, steam driven machinery, relief valves, pumps, fans, and blowers.

OWCP referred appellant, together with a statement of accepted facts, to Dr. Jeffrey Powell, a Board-certified otolaryngologist, for a second opinion evaluation on February 9, 2016. An audiogram was completed that same date which revealed the following decibel (dB) losses at 500, 1,000, 2,000, and 3,000 hertz (Hz): 20, 20, 25, and 45 for the right ear and 30, 15, 20, and 45 for the left ear. Dr. Powell reported that appellant had problems localizing sound and understanding words in a group conversation, especially with background noise. He first noticed his hearing loss 10 years ago which had significantly worsened over the years. Appellant further complained of tinnitus in both ears that was high pitched and constant which disturbed him both while he was awake and also when trying to sleep.

Dr. Powell diagnosed binaural noise-induced high frequency neurosensory hearing loss and binaural tinnitus as a result of his occupational noise exposure in his federal employment. He noted that appellant's audiogram at the beginning of his employment in 1985 revealed normal thresholds and his most recent audiograms showed a significant threshold shift, revealing a severe high frequency noise-induced neurosensory hearing loss. Dr. Powell further stated that appellant's workplace noise exposure was sufficient as to intensity and duration to have caused the loss in question and the hearing loss was well in excess of what would normally be predicated on the basis of presbycusis. He indicated that appellant had reached maximum medical improvement (MMI) and recommended hearing aids.

Applying the standard provided by the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*³ (A.M.A., *Guides*) to the February 9, 2016 audiometric data, Dr. Powell calculated that appellant sustained 10.63 percent monaural hearing impairment in the right ear (5.63 percent⁴ + 5 percent for tinnitus) and 8.75 percent monaural hearing impairment in the left ear (3.75 percent + 5 percent for tinnitus). He calculated a binaural hearing impairment of 9.06 percent.

³ A.M.A., *Guides* (6th ed. 2009).

⁴ The Board notes that Dr. Powell noted 25 dB at 500 Hz when calculating the right ear monaural hearing loss. The February 9, 2016 audiogram reveals that the dB level at 500 Hz was actually 20 dB.

By decision dated February 25, 2016, OWCP accepted appellant's claim for binaural hearing loss and binaural tinnitus. It further noted that the record established that he would benefit from hearing aids.

On August 5, 2016 OWCP referred the case file to Dr. Jeffrey M. Israel, an OWCP district medical adviser (DMA) and Board-certified otolaryngologist, to determine the extent of appellant's hearing loss and permanent impairment due to his employment-related noise exposure.

On April 8, 2016 Dr. Israel reviewed Dr. Powell's February 9, 2016 otologic examination report and agreed that appellant's binaural high frequency sensorineural hearing loss was due to occupational noise exposure. He applied the audiometric data to OWCP's standard for evaluating hearing loss under the sixth edition of the A.M.A., *Guides* and determined that appellant sustained 3.75 percent monaural hearing impairment in the right ear, 3.75 percent monaural hearing impairment in the left ear, and a binaural hearing impairment of 3.75 percent.⁵

Dr. Israel averaged appellant's right ear hearing levels of 20, 20, 25, and 45 dB at 500, 1,000, 2,000, and 3,000 Hz, which totaled 27.5. After subtracting out a 25 dB fence, he multiplied the remaining 2.5 balance by 1.5 to calculate a 3.75 percent right ear monaural hearing loss.⁶ Dr. Israel then averaged appellant's left ear hearing levels of 30, 15, 20, and 45 dB at 500, 1,000, 2,000, and 3,000 Hz, which totaled 27.5. After subtracting out a 25 dB fence, he multiplied the remaining 2.5 balance by 1.5 to calculate a 3.75 percent left ear monaural hearing loss. Dr. Israel then calculated 3.75 percent binaural hearing loss by multiplying the right ear loss of 3.75 percent by 5, adding the 3.75 percent left ear loss, and dividing this sum by 6. He added no percentage for tinnitus. Dr. Israel acknowledged that appellant had tinnitus and that Dr. Powell added five percent tinnitus loss to each ear. He deferred to Dr. Powell's tinnitus rating stating that there was no Tinnitus Handicap Inventory available for him to review. Dr. Israel concluded that hearing aids were authorized and noted the date of MMI as February 9, 2016.

On April 27, 2016 appellant filed a claim for a schedule award (Form CA-7).

By decision dated June 2, 2016, OWCP granted appellant a schedule award for 3.75 percent binaural hearing loss. The date of MMI was determined to be February 9, 2016. The award covered a period of eight weeks from February 9, 2016 to April 4, 2016.

LEGAL PRECEDENT

The schedule award provision of FECA⁷ and its implementing regulations set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does not

⁵ *Supra* note 3 at 249.

⁶ Dr. Israel noted that his values were different from Dr. Powell's as the physician misread the right ear dB level at 500 Hz.

⁷ *Supra* note 2.

specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* (6th ed. 2009), has been adopted by OWCP for evaluating schedule losses and the Board has concurred in such adoption.⁸

OWCP evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides*. Using the frequencies of 500, 1,000, 2,000, and 3,000 cycles per second, the losses at each frequency are added up and averaged. Then, the fence of 25 decibels is deducted because, as the A.M.A., *Guides* points out, losses below 25 decibels result in no impairment in the ability to hear everyday speech under everyday conditions.⁹ The remaining amount is multiplied by a factor of 1.5 to arrive at the percentage of monaural hearing loss. The binaural loss is determined by calculating the loss in each ear using the formula for monaural loss; the lesser loss is multiplied by five, then added to the greater loss and the total is divided by six to arrive at the amount of the binaural hearing loss. The Board has concurred in OWCP's adoption of this standard for evaluating hearing loss.¹⁰

Regarding tinnitus, the A.M.A., *Guides* provide that tinnitus is not a disease but rather a symptom that may be the result of disease or injury.¹¹ The A.M.A., *Guides* state that if tinnitus interferes with [Activities of Daily Living (ADLs)], including sleep, reading (and other tasks requiring concentration), enjoyment of quiet recreation, and emotional well-being, up to five percent may be added to a measurable binaural hearing impairment.¹²

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.¹³ OWCP may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.¹⁴

⁸ See *R.D.*, 59 ECAB 127 (2007); *Bernard Babcock, Jr.*, 52 ECAB 143 (2000).

⁹ See A.M.A., *Guides* 250.

¹⁰ See *E.S.*, 59 ECAB 249 (2007); *Donald Stockstad*, 53 ECAB 301 (2002), *petition for recon. granted (modifying prior decision)*, Docket No. 01-1570 (issued August 13, 2002).

¹¹ See A.M.A., *Guides* 249.

¹² *Id.* See also *Robert E. Cullison*, 55 ECAB 570 (2004); *R.H.*, Docket No. 10-2139 (issued July 13, 2011).

¹³ See Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013); *Hildred I. Lloyd*, 42 ECAB 944 (1991).

¹⁴ See *Ronald J. Pavlik*, 33 ECAB 1596 (1982).

ANALYSIS

OWCP accepted appellant's claim for binaural noise-induced hearing loss and binaural tinnitus. The issue is whether appellant has more than a 3.75 percent binaural hearing loss for which he received a schedule award. The Board finds that the evidence of record establishes that appellant has a 8.75 percent binaural hearing loss.¹⁵

OWCP referred appellant, together with a statement of accepted facts, to Dr. Powell, a Board-certified otolaryngologist, for a second opinion evaluation. An audiogram was completed on February 9, 2016 which revealed the following dB losses at 500, 1,000, 2,000, and 3,000 Hz: 20, 20, 25, and 45 for the right ear and 30, 15, 20, and 45 for the left ear. Dr. Powell diagnosed binaural noise-induced high frequency neurosensory hearing loss and binaural tinnitus as a result of his federal occupational noise exposure.

The Board finds that Dr. Powell, the second opinion physician, properly evaluated appellant's left ear hearing loss. Using the February 9, 2016 audiogram, Dr. Powell averaged appellant's left ear hearing levels of 30, 15, 20, and 45 dB at 500, 1,000, 2,000, and 3,000 Hz, which totaled 27.5. He then subtracted a 25-dB fence and multiplied the balance of 2.5 by 1.5 to find 3.75 percent left ear monaural hearing loss.

With respect to appellant's right ear hearing loss, Dr. Powell mistakenly calculated appellant's right ear monaural loss using 25 dB at 500 Hz rather than the 20 dB noted in the audiometric test results. Nonetheless, he properly evaluated appellant's right ear hearing levels of 20, 20, 25, and 45 dB at 500, 1,000, 2,000, and 3,000 Hz to average 27.5. Subtracting a 25 dB fence and multiplying the balance of 2.5 by 1.5 results in 3.75 percent left ear monaural hearing loss.

Applying the February 9, 2016 audiometric data and using the sixth edition of the A.M.A., *Guides*, Dr. Powell calculated that appellant sustained 3.75 percent monaural hearing impairment in the right ear and 3.75 percent monaural hearing impairment in the left ear.¹⁶ He calculated a binaural hearing impairment rating of 3.75 percent.

Dr. Powell further diagnosed tinnitus. He described appellant's symptoms as trouble localizing sound and understanding words in a conversation, especially with background noise. Dr. Powell further noted that appellant was experiencing constant high pitch ringing which disturbed him both while he was awake and also when trying to sleep.

OWCP then referred the medical evidence to Dr. Israel serving as OWCP's DMA for a rating of permanent impairment in accordance with the A.M.A., *Guides*. The DMA agreed that appellant had a 3.75 percent binaural hearing loss under the sixth edition of the A.M.A., *Guides* based on the results of the February 9, 2016 audiogram and Dr. Powell's second opinion report. Though Dr. Israel did not include five percent impairment for tinnitus, he noted that he was deferring to Dr. Powell with regards to his tinnitus rating.

¹⁵ C.W., Docket No. 13-1168 (issued October 23, 2013).

¹⁶ *Supra* note 11.

The Board finds that Dr. Powell properly added another 5 percent for tinnitus as it impacted appellant's ability to perform activities of daily living, for a total left ear monaural hearing loss of 8.75 percent. Accordingly, the Board will grant an additional five percent award for tinnitus.¹⁷

Thus, the Board finds that appellant sustained 9 percent binaural hearing loss (rounded up from 8.75).¹⁸ The Board further finds that OWCP properly determined that the date of MMI was February 9, 2016, the date of Dr. Powell's examination.¹⁹

CONCLUSION

The Board finds that appellant has established that he has nine percent permanent binaural hearing loss.

¹⁷ R.A., Docket No. 15-138 (issued March 13, 2015).

¹⁸ The policy of OWCP is to round the calculated percentage of impairment to the nearest whole point. Results should be rounded down for figures less than .5 and up for .5 and over. *See* FECA Procedure Manual, Part 3 - Medical, *Schedule Awards*, Chapter 3.700.3(b) (January 2010); *Carolyn E. Sellers*, 50 ECAB 393, 394 (1999).

¹⁹ In assessing eligibility for a schedule award, the medical evidence must show that the impairment has reached a permanent and fixed state, which is generally referred to as MMI. *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5b(1) (February 2013). Assuming MMI has been attained, the date of MMI is usually considered to be the date of the evaluation by the attending physician that is accepted as definitive by OWCP. Schedule awards begin on the date of MMI, unless circumstances show that a later date should be used. A retroactive determination of the date of MMI is not per se erroneous. When the medical evidence establishes that the employee did in fact reach maximum improvement by such date, the determination is proper. *Id.* at Chapter 2.808.7b.

ORDER

IT IS HEREBY ORDERED THAT the June 2, 2016 decision of the Office of Workers' Compensation Programs is affirmed, as modified.

Issued: March 15, 2017
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board